

Prospect Assessment Form

1. Senior ?
2. Person with disability?
3. Home ?
4. CLS ?

Name:								
Address:			Primary Language:					
City, State, Zip: ,			Advance Directives:		DNR:			
DOB:		Phone:	Yes	No	Yes	No		
			Location:		Location:			
Primary Contact:			Relationship:		May Assist in care decisions:			
Phone 1:			Phone 2:		Phone 3:			
Secondary Contact:			Relationship:		May Assist in care decisions:			
Phone 1:			Phone 2:		Phone 3:			
Physician Name:			Type of Physician:		Phone:			
Address:			Preferred Hospital:					
City, State, Zip: ,			Hospital Phone:					
List all needed services?:		3.	Other Healthcare Providers:					
1.		4.	Contact Name:					
2.		5.	Policy #:					
			Phone #:					
Medical History								
Alzheimer's		Allergies		Blood Pressure Issues				
Disabilities ?		Cancer		Blind				
Breathing Issues		Chronic Pain		Dementia:				
Diabetes		Falls / Balance:		Hearing Issues:				
Heart Issues		Incontinence		Memory Issues				
Parkinson's Dz:		Paralysis		Recent Surgery:				
Seizures		Speaking Issues:		Stroke				
Tremors		Wounds		Vision Issues:				
Supportive Devices								
Device	Yes / No	Needs	Device	Yes / No	Needs	Device	Yes / No	Needs
Ambulatory:			Bedside Commode			Cane		
Dentures			Emergency Response System			Furniture Raised:		
Glasses			Grab Bars in Bathroom			Hand Held Shower		
Hearing Aid			Hospital Bed			Lift Chair		
Mobility Cart			Other:			Oxygen		
Raised Toilet Seat / Arm Rest			Ramps			Shower Chair / Bench		
Stair / Bed Rails			Transfer Board			Walker		
Wheelchair								
Assessment Form Note								

Customer Signature: _____

Date: _____

Signature: _____

Date: _____

____/____/____

Office # _____
 Primary Contact: _____
 Client Contact Person _____

Advance Directives:	Yes	No	Location	_____
DNR:	Yes	No	Location	_____

Description / Instructions

- Bathing
- Change clothings
- Eat breakfast
- Eat dinner
- Eat Lunch
- Favorite Activities
- Favorite desserts
- Favorite Meals
- Friendly Reminders
- Grooming
- Makeup
- Medications reminder
- Memory Games
- Midday rest
- Midday Snack
- Oral Care

Companionship and Homemaking

Description / Instructions	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Request
Any Money balance?								
Any Receipts?								
Grocery Shopping								
Light chores								
Light Housekeeping								
Meal Preparation								
Medications reminder								
Personal errands								
Transpotation								

Activities developed with Client / Family Input

Customer Signature: _____ Date: _____
 Signature: _____ Date: _____